RETIRED COVERAGE ENROLLMENT APPLICATION

State Health Benefits Program - School Employees' Health Benefits Program
New Jersey Division of Pensions and Benefits
P.O. Box 299 • Trenton, NJ 08625-0299

HR-0801-0908

1. APPLICANT INFORMATION

Were you a part time employee when you retired? ☐ Yes ☐ No

Social Security Number ___ – ___ – ____

Last Name | Title (Jr., Sr., etc.)

First Name | Middle Name

Street Address | Apartment #

PO Box | City | State

Zip Code + 4 | Date of Birth (mm/dd/yy) | Gender (M/F)

Status (check one) ☐ Single ☐ Married ☐ Civil Union (see instructions) ☐ Divorced ☐ Widowed ☐ Domestic Partnership (see instructions)

Former Employer _____

Area Code | Home Telephone Number | Date of Retirement (mm/dd/yy)

	YES	NO
Do YOU have Medicare Part A? (Hospital Insurance)		
Do YOU have Medicare Part B? (Medical Insurance)		
Does YOUR SPOUSE/PARTNER have Medicare Part A?		
Does YOUR SPOUSE/PARTNER have Medicare Part B?		

Anyone eligible for Medicare (age 65 or older or in receipt of Social Security Disability benefits for at least 24 months) must be enrolled under both Medicare Part A (Hospital) and Part B (Medical) in order to continue coverage under this program. If enrolled, a photocopy of the Medicare card must be submitted with this application.

If your child has Medicare, list child's name and Social Security Number _____ and attach a copy of the Medicare card.

2. TYPE OF ACTIVITY

— Submit this application if you are a **new enrollee** for SHBP or SEHBP Retired Group coverage. Check one box in Section 2A; then complete Sections 3 and 4 to select Medical/Dental Coverage. If you are already enrolled and wish to change coverage, add or delete dependents, or cancel coverage, please submit the *Retired Change of Status Application.*

2A. ENROLLMENT ACTION REQUESTED

☐ New Retiree

☐ Survivor Enrollment: Decedent's SS# _____

3A. MEDICAL COVERAGE (Check one box only).

☐ I wish to be covered under **NJ DIRECT15**

☐ I wish to be covered under **NJ DIRECT10** (Certain State retirees may be ineligible for NJ DIRECT10. See the *NJ DIRECT Member Handbook* for eligibility information.)

☐ I wish to be covered under **Aetna HMO.**
(Enter Aetna HMO Primary Care Physician's ID#)

☐ I wish to be covered under **CIGNA HealthCare HMO.**
(Enter CIGNA HealthCare Primary Care Physician's ID#)

☐ **I do not wish to be covered** under any of the medical plans (See instructions)

☐ **I wish to waive coverage** under the medical plans for the following reason: (See instructions)

☐ I have coverage with another employer ☐ I have coverage with spouse/partner's employer

List Employer _____

☐ Other (Give Reason) _____

3B. LEVEL OF COVERAGE (Check one box)

☐ Single ☐ Member & Spouse/Civil Union Partner (See Instructions)

☐ Family ☐ Parent/Child(ren) ☐ Member & Domestic Partner (See Instructions)

4A. DENTAL COVERAGE (Check one box only)

☐ I wish to be covered by the **Retiree Dental Expense Plan**

☐ **I do not wish to be covered** under the dental plan (See instructions)

☐ **I wish to waive coverage** under the dental plan for the following reason: (See instructions)

☐ I have coverage with another employer ☐ I have coverage with spouse/partner's employer

List Employer _____

4B. LEVEL OF COVERAGE (Check one box)

☐ Single ☐ Member & Spouse/Civil Union Partner (See Instructions)

☐ Family ☐ Parent/Child(ren) ☐ Member & Domestic Partner (See Instructions)

4C. PREVIOUS DENTAL COVERAGE

Were you enrolled in a group dental plan for at least 12 months prior to retirement?

☐ Yes ☐ No

If yes, please provide:

Dental Plan Name _____

Telephone Number _____

Your Dental Plan ID Number _____

5. DEPENDENT INFORMATION — List eligible dependents you wish to include on your coverage. If necessary, attach another sheet of paper.

	Last Name	First Name	MI	Date of Birth (mm/dd/yy)	Gender (M/F)	Social Security Number	Dependent's HMO Primary Care Physician ID#	Natural (C) Adopted (A) Foster (F) Step (S) Legal Ward (L) See Instructions
☐ Spouse/Partner								
Eligible Children								

FOR DIVISION USE ONLY

Event Reason | Effective Date

Waiver Code | Location No.

Waiver Codes: 3 - (voluntary) 4 - (non-response) 5 - (spouse) 6 - (employer)

6. I certify that all the information supplied on this form is true to the best of my knowledge. I authorize a pension deduction from my pension check, including initial check, last check benefit, withdrawal check, or return of contributions check as required by the State Health Benefits Commission or School Employees' Health Benefits Commission. I also understand that there is no guarantee of continuous participation by medical service providers, either doctors or facilities in the NJ DIRECT or HMO plans. I authorize any hospital, physician, dentist, or health or dental care provider to furnish my medical/dental plan or its assignee with such medical/dental information about myself, or my covered dependents on this application, as the assignee may require. I further authorize my current dental plan, if applicible, to release information deemed necessary for enrollment in this plan. **Anyone eligible for Medicare (age 65 or older or in receipt of Social Security Disability benefits) must be enrolled under both Hospital Insurance (Part A) and Medical Insurance (Part B) in order to continue coverage under this program. PROOF OF ENROLLMENT IS REQUIRED.** If I or a covered dependent enroll in Medicare at a later date, I understand that the Health Benefits Bureau must be notified immediately.

Applicant's Signature _____ Date: _____

☐ Additional Sheet Attached ☐ Medicare Proof Enclosed

COMPLETING THE RETIRED COVERAGE ENROLLMENT APPLICATION

Be sure to review Fact Sheet #11, *Enrolling in Health Benefits Coverage When You Retire*, to verify that you are eligible for enrollment into the **State Health Benefits Program** (SHBP) or **School Employees' Health Benefits Program** (SEHBP).

SECTION 1 — APPLICANT INFORMATION

This section pertains to the person enrolling in the retired group. Complete all requested information, filling in one letter or number per block. Provide month, day, and year for Date of Birth and Date of Retirement (for example: April 12, 1933 = 04 12 33). Please indicate if you were a part-time employee.

SECTION 2 — TYPE OF ACTIVITY

Check one box in section 2A. If you have applied for retirement or are a new retiree, check the first box "New Retiree".

If you are enrolling as a Surviving Spouse/Partner or Surviving Dependent, check "Survivor Enrollment."

For changes to existing retired group health benefits coverage **DO NOT USE THIS FORM.** To change plans, add or delete dependents, cancel coverage, and make other changes, SHBP or SEHBP members should complete and submit the *Retired Change of Status Application.*

SECTION 3 — MEDICAL PLAN SELECTION

Check only one box indicating either: **1.**) The medical plan into which you want to enroll; or **2.**) That you do not want medical plan coverage (See "Declining or Waiving Coverage" below); or **3.**) That you want to waive medical plan coverage. (See "Declining or Waiving Coverage" below)

When choosing a HMO plan you must list the identification number (ID #) of your Primary Care Physician.

DECLINING OR WAIVING COVERAGE — If you are declining coverage and do not want SHBP or SEHBP coverage, check the box indicating that you do not wish to be covered under any of the medical/dental plans.

If you are requesting to waive enrollment for yourself and any of your eligible dependents because of other group health or dental insurance coverage from a public or private employer, check the box indicating that you wish to waive coverage, indicate if the coverage is through your employment or that of your spouse/partner, and the name of the employer. If coverage is waived you may in the future be able to enroll yourself and your eligible dependents in a SHBP or SEHBP medical or dental plan, provided that you request enrollment within 60 days after your other employer group health or dental coverage ends — proof of loss of coverage is required. See Fact Sheet #11, *Enrolling in Health Benefits Coverage When You Retire*, for more information. Police and Firemen's Retirement System (PFRS) members enrolling under Chapter 330, P.L. 1997 should refer to Fact Sheet #47, *Retired Health Benefits Coverage Under Chapter 330*, for more information.

LEVEL OF COVERAGE — Select a level of coverage based upon who you will be covering. Your eligible dependents are your spouse or civil union partner (attach a copy of the *Marriage Certificate* or *Certificate of Civil Union* if this is your first time enrolling in the SHBP or SEHBP), or an eligible same-sex domestic partner (see definition below), and your unmarried children under age 23 who live with you in a regular parent-child relationship. (This includes children who are away at school.) If you are divorced, your children who do not live with you are eligible if you are legally required to support those children. Step children, foster children, legally-adopted children, and legal wards are also eligible provided they live with you and are substantially dependent upon you for support and maintenance. An *Affidavit of Dependency* form and legal documentation are required for these cases if you have not previously provided this to the Health Benefits Bureau. You will be sent an *Affidavit of Dependency* if required once your application is received.

When you first enroll at the time of retirement, you may add eligible dependents.

(***Note:*** Dependents may be added later, using the *Retired Change of Status Application,* either within 60 days of the date of event - i.e., marriage, civil union, birth of a child - with an effective date of the date of the event; or added timely with a 60-day waiting period.)

Indicate whether you and/or your spouse/partner and/or child are enrolled in Medicare Parts A and B. Be sure to list the effective dates of the Medicare enrollment. Proof of full Medicare enrollment in Parts A and B is required by the Health Benefits Bureau. Please submit a photocopy of the Medicare card or a letter from Social Security confirming the effective dates of full Medicare enrollment. Members receiving a Social Security Disability who become Medicare eligible, must be enrolled in the full Medicare program — Part A and Part B — in order to have coverage in the SHBP or SEHBP. If submitting proof of Medicare enrollment, check the box at the bottom right of the application.

SPOUSE: This is a person of the opposite sex to whom you are legally married. A photocopy of the *Marriage Certificate* is required for enrollment.

CIVIL UNION PARTNER: This is a person of the same sex with whom you have entered into a civil union. A photocopy of the New Jersey *Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions is required for enrollment. The cost of a civil union partner's coverage may be subject to federal tax (see Fact Sheet #75, *Civil Unions,* for details).

DOMESTIC PARTNER: This is a same-sex domestic partner, as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act, of any State employee, State retiree, or an eligible employee or retiree of a SHBP or SEHBP participating local public entity if the local governing body adopts a resolution to provide Chapter 246 health benefits. A photocopy of the New Jersey *Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another jurisdiction that recognizes same-sex domestic partners is required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see Fact Sheet #71, *Benefits Under the Domestic Partnership Act,* for details).

SECTION 4 — DENTAL EXPENSE PLAN SELECTION

If eligible, check only one box indicating either: **1.**) that you want to enroll in the Retiree Dental Expense Plan; or **2.**) That you do not want dental coverage (See "Declining or Waiving Coverage" above); or **3.**) That you want to waive dental coverage. (See "Declining or Waiving Coverage" above)

Select a level of coverage based upon who you will be covering. See "Level of Coverage" above for details.

SECTION 5 — SPOUSE/PARTNER AND DEPENDENT INFORMATION

This section is used for members selecting Member & Spouse/Partner, Family, or Parent & Child(ren) coverage. Please list your spouse,/partner's name, gender, date of birth, Social Security number, and if enrolling in an HMO plan the spouse/partner's Primary Care Physician Identification Number. Please also list the name, gender, date of birth, Social Security number, and if enrolling in an HMO plan the Primary Care Physician Identification Number for any dependent children you are enrolling. If you are listing more than two children, please provide the required information for your other children on an additional sheet of paper, attach the sheet to the application, and check the box at the bottom right of the application.

SECTION 6 — CERTIFICATION AND SIGNATURE

The member must read the certification and sign and date the application. If Medicare proof or additional sheets are submitted with the application, check the box indicating such.

Misrepresentation: Any person who provides false or misleading information is subject to criminal and civil penalties.

Return this application and all supporting documentation to:

NJ DIVISION OF PENSIONS AND BENEFITS
HEALTH BENEFITS BUREAU
P.O. BOX 299
TRENTON, NJ 08625-0299